Productivity Commission Inquiry into Introducing Competition and Informed User Choice into Human Services

Productivity Commission Study Report

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1 Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Productivity Commission on their second stage of the inquiry on *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* (hereafter referred to as the Study Report).

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

While the Productivity Commission's inquiry examines a diverse array of human services, the AHHA submission to the inquiry addresses only increased user choice and contestability as they relate to health and health related components of human services.

The healthcare sector is complex in its provision of human services which are delivered by a variety of providers with various funding sources, spread across different levels of government and third party agents. There is also a high degree of information asymmetry between consumers and healthcare providers, placing significant emphasis on the principal-agent relationship between the patient and care provider. The complexity and interwoven nature of the healthcare sector necessitates careful policy design around reforms, to ensure that the broad system impacts and the potential for unintended consequences are considered.

The Commission's characteristics of human services to assist service reform design (Figure 2) are generally supported by the AHHA. However, in addition to these criteria it is necessary to recognise and include the service user characteristics of information asymmetry, affordability and timely access to health-related human services, in addition to the government stewardship role to ensure equity of healthcare across Australia.

While the AHHA supports the need for greater access to high-quality user information around health services, it has concerns with reforms to increase competition and contestability of health-related services in the public sector. Any changes to increase competition and contestability must be carefully evaluated to ensure that any impact in system costs will be adequately offset by improved health care quality, equity and value.

In previous submissions by the AHHA to the Productivity Commission reports on *Human Services: Identifying Sectors for Reform*, some general principles were outlined as necessary pre-conditions when examining the scope for effective increased competition in human services in the health sector. Given the importance of these principles in assessing any proposed change to market conditions in the delivery of healthcare services, they are reiterated here:

- Increased competition can only be realised with appropriate **transparency**. This includes transparency related to both individual health practitioners and provider groups with respect to:
  - Appropriate alternatives for the provision of needed healthcare
  - Pricing practices and costs
  - Health outcomes achieved
  - Quality of healthcare provided across appropriate dimensions
  - Prospective delays in receiving treatment

- Increased competition can only be realised with appropriate consumer **health literacy**. This includes:
    - Access to relevant authoritative health information
    - The individual having the capacity to understand and act appropriately with this information, and noting that this will be different for different people and in different circumstances
    - The existence of an appropriate principal-agent relationship between the patient and their healthcare provider with expert guidance to properly enable **informed consumer choice**
- Relevant individual healthcare **data is portable** to enable alternative healthcare practitioners and providers to feasibly provide a competitive alternative. Characteristics of portable data include:
    - Data structures are compatible across vendor applications and use common clinical coding systems
    - Individual health data is maintained in real time
    - Appropriate safeguards are in place to ensure patient confidentiality and health care data security
- The varying **context** in which otherwise similar healthcare is needed means that a change in competition settings will not always work the same way in different settings eg what is feasible in urban settings may not be feasible in non-urban settings implying the need for regionally tailored approaches to competition settings
- There is currently a wide recognition within the health sector of the importance of **integrated healthcare** in achieving better health outcomes, and better use of resources and competition policy should not create perverse or short-term incentives that work against this objective
- Individually short-term rational decisions should not be at the expense of long-term **sustainable health outcomes** or broader **whole-of-system technical efficiency**
- **Funding mechanisms** influence what healthcare services are provided and where they can be provided
- Any increase in competition should not cause an increase in **health inequalities** through perverse incentives or otherwise unintended consequences
- The impact of entrenched professional cultures that prevents clinically safe **expanded scope of practice** consistent with inter-disciplinary competencies must be addressed

Support Necessary for Consumers

AHHA supports the principle of improving consumer-oriented information and increasing consumer choice for services. However, it cautions that consumers will have varying capacities to understand and use this information to make informed decisions as health literacy will vary between individuals and the circumstances in which treatment choices are made. This requires timely, meaningful and consumer relevant data to be complemented by aids to improve health literacy and empower individuals to better manage their health, in addition to support from treating health professionals in making decisions.

In line with increasing consumer health literacy and empowerment, system navigators, or professionals tasked with assisting and enabling consumers to navigate within and across the complex care systems, may be of benefit. This is likely to have greater utility for those consumers with complex care needs or reduced capacity to make informed choices.

Competition and Contestability

In considering the introduction of competition for human services in the healthcare sector it is necessary to reflect on which services are appropriate for a particular setting, which will vary depending on the minimal economic and clinical scale necessary to ensure that care is of high-quality and delivered efficiently[1]. In those more specialist areas of healthcare such as hospitals and/or where the market is smaller, competition can result in poorer outcomes and inefficient use of resources. Throughput of patients is necessary to ensure that staff have adequate clinical practice to maintain their skills and remain technically efficient.

Important lessons can be gained from the implementation of the National Disability Insurance Scheme. Early insights from the seven National Disability Insurance Scheme trial sites suggest that it could take more than a decade for markets to mature to a substantially revised policy, funding and consumer controlled setting.[2] There is also a recognition that this may never occur within some rural and remote areas, with an associated need for ongoing direct government intervention.[3]

These findings reinforce that the provision of healthcare services is a complex mix of quality and safety standards, funding arrangements, rational behaviour by self-motivated non-government operators, varying operational environments, and groups with differing special needs, with this all occurring in an environment with a high degree of information asymmetry and often sub-optimal capacity for consumers to make truly informed choices. The AHHA supports moves to improve the efficiency of the health system, but careful policy design is essential to ensure that changes occur within a strategic policy framework that considers broader system impacts.

Government Stewardship

The AHHA supports the concept that well-designed reform, underpinned by strong government stewardship, could improve service quality, accessibility and consumer choice. However, the Study Report does little to articulate how government stewardship would be strengthened, and implemented within a private sector where its policy levers, and its capacity to provide stewardship, are limited. Exemplifying this is: the limited control it has been able to exert over the private health sector regarding provision of data for health statistical collections, acknowledged as critical for improving the effectiveness of human services provision[4]; and regarding the use of a national electronic health record (notwithstanding substantial government investment in electronic health record infrastructure).

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[1] Dash P and Meredith D. 2010. When and How Provider Competition can Improve Health Care Delivery. *McKinsey Quarterly: Healthcare Payor and Provider Practice*, 1-12.

[2] Easton S. 2015. CEO's Lessons From the NDIS: Scaling Individualised Services. The Mandarin (accessed 10 October 2016).

[3] Kerr-Smith E. 2015. Annie's Story, and Getting the NDIS Right. The Mandarin (accessed 10 October 2016).

[4] AIHW. National Health Reform Performance and Accountability Framework. Available at: http://www.aihw.gov.au/health-performance/performance-and-accountability-framework/.

AHHA Recommendations

AHHA proposes the following measures should underpin the provision of all health-related services in the public sector, whether delivered by government-owned and controlled agencies or outsourced to the not-for-profit or private sector via competitive and contestable arrangements:

1. To improve **health outcomes** – apply a values based health care model to achieve the best outcomes at the lowest cost
2. To improve **quality** – all services providing publicly funded care must be accredited and report clinical quality indicators
3. To improve **equity** – funding must be based on a universal health care principle
4. To improve **efficiency** – apply a funding model that is measurable by health outcome indicators and that applies risk adjusted funding that supports service delivery to populations that have access issues
5. To improve **accountability and responsiveness** – ensure timely public reporting of health outcome indicators that are clinically meaningful

2 Proposal to Introduce Competition into Public Hospital Services

The Commission must ensure that recommendations intended to improve technical or allocative efficiency in part of the care system do not occur at the expense of other parts of the system.[5] A realistic whole-of-system assessment must be made of any proposals. One pertinent example in the context of hospital care is the recognised importance of coordinated care beyond the hospital walls.

Current Models of Public Hospital Service Delivery

The Study Report notes that while Australian hospitals generally perform well against comparable countries, there is scope to improve outcomes for patients and to lower costs by benchmarking against better performing Australian hospitals. This requires the development and reporting of clinically meaningful and consumer relevant hospital performance indicators in a timely manner.

Australia's universal healthcare system enables eligible patients receiving public hospital services to obtain care at no direct cost. For many consumers there is no practical alternative public hospital that can be selected (eg if the nearest geographic alternative involves an unreasonable travel burden) and there are many regional areas where private hospitals have not been established, presumably because a market analysis suggests that such services would not be commercially viable. Notwithstanding these limitations, increased consumer choice may foster improvements to service quality and access in some locations. However it could also result in increased out-of-pocket costs for consumers, impacting affordability and equity, and may present risks to system sustainability. As illustrated in the predominantly private market of the United States, health expenditure has risen to 16.9% of GDP in contrast to 9.3% in Australia.[6]

If consumers respond strongly to increasing public hospital competition by seeking out higher performing clinicians or hospitals, with reduced demand for what is perceived as lower quality services, the risk profile and efficiency of each facility will be altered, and may well result in services or hospitals becoming operationally and financially unsustainable. Of concern is the impact this would present for public hospitals in remaining accessible and responsive to local community need, particularly for smaller regional services.

While continual improvement and increased accountability of public hospitals is necessary, this is more feasibly achieved through expansion of timely public reporting. To enhance transparency, public reporting measures must be timely, provided in a user-friendly manner, be clinically meaningful and relevant to the consumer. This could provide impetus to improve practice and boost performance in lower performing hospitals.

Public reporting of clinically relevant patient outcome data should also be provided at a level appropriate to inform consumer decision-making. While the MyHospitals website currently provides hospital level data on waiting times and average lengths of stay for limited conditions, it may be more appropriate to provide patient outcome data at the clinical service level or at the level of the clinician led hospital team. This enhanced public reporting would allow individuals to identify those services or teams with better performance, and may encourage hospitals, services and teams to improve performance and patient outcomes.

There are already some mechanisms in place that provide incentives for public hospitals to work towards more efficient levels of operational performance. Standardised pricing provided through the Activity Based Funding framework for clinically similar episodes of care is one such example. The steady

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[5] The care system is a broader view of the many sectors that interact in the delivery of care to individuals and across the life course. This includes community, primary, specialists, acute, aged, disability, dental and palliative care systems.

[6] OECD. 2017. Health Expenditure and Financing: Health Expenditure Indicators. *OECD Health Statistics (database)*, http://dx.doi.org/10.1787/data-00349-en (accessed on 26 January 2017).

decrease in the National Efficient Price over recent years is evidence of the positive impact this has had on system performance. The report on healthcare variation in Australia similarly highlights the significant variation in admission rates for selected conditions at local area level (SA3).[7] Service level agreements between state and territory governments and their local health networks is another mechanism for targeted improvements by public hospitals.

The Commission must also be cautious to recognise the variety of constraints that different public hospitals can face that can make average levels of performance difficult to achieve. The age of a facility, difficulties attracting and retaining the medical and related workforce, and the special needs of particular groups within the catchment of a public hospital can all create circumstances that justify variation in performance. Deviation from a benchmark does not unambiguously point to sub-standard performance.

Overall, greater transparency around clinically meaningful and consumer relevant hospital performance indicators available in a timely manner could provide incentives to public hospitals to change practices and facilitate some improved consumer choice. However, this also raises system issues that go beyond the performance of individual establishments, and requires national stewardship from government, for example, to invest in development of outcome measures for inclusion in the National Health Performance Framework.

Greater User Choice in Public Hospital Services

Previous Productivity Commission reports have stated that, “greater user choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.” Australians are currently not prevented from attending a public hospital of their choice, though with limited information on individual hospital performance, this choice will often be based primarily on access convenience (in terms of travel time and waiting lists). However, if competition in the provision of public hospital services by private providers was introduced as appears to be alluded to, then this raises a larger set of issues than simply providing more consumer choice.

If the private sector was able to compete for the offer of services to public patients, governments would likely require some mechanism for demand management with what is an open ended commitment to the provision of public hospital services. Currently this is managed through existing public hospital system capacity. If the capacity for public hospital services was expanded this could generate a supplier-induced demand effect, as would be observed for example through a diminishing of waiting lists. Over-supply is observed in the private sector, where un-capped demand has led to a growth in elective surgery procedures and increasing expenditure in private hospitals.[8]

It is also likely that many private providers would not be willing to take on more complex cases due to the clinical and financial risk associated with these patients. Such risk-averse selection of patients by private providers would then impact on the types of patients public hospitals are left to treat. If private hospitals are enabled to provide care for public patients, then they should also be required to deliver the entire episode of care, including after care and managing complications. Currently many complications of privately delivered care are picked up by public hospitals.[9] While this makes the private system appear to have good outcomes (eg low length of stay and readmission rates), the flow-on impact to public hospitals and rehabilitation mask the real outcomes and system performance.

[7] Australian Commission on Safety and Quality in Health Care (ACSQHC). 2017. Australian Atlas of Healthcare Variation. Sydney: ACSQHC.

[8] Doiron D, Fiebig DG, and Suziedelyte A. 2014. Hips and Hearts: The Variation in Incentive Effects of Insurance across Hospital Procedures. *Journal of Health Economics*, 37, 81–97

[9] Cheng TC, Haisken-DeNew JP and Yong J. 2015. Cream Skimming and Hospital Transfers in a Mixed Public-Private System. *Social Science & Medicine*, 132, 156-164.

The implications of managing a public hospital delivering emergency care and care of 'last resort' in such an environment affords its own complications. Providing universal healthcare in such a facility that is accessible, equitable and responsive to local need could be severely impacted by limitations on cost-effectiveness, economies of scale and the distribution of risk across the system. Positive externalities achieved by maintaining skills and practice of health professionals within these facilities could also be compromised.

Access to Useful Consumer-Orientated Information

AHHA recommends that the provision of useful consumer-orientated information on services is complemented by support in making decisions by referring health professionals. This would require the timely availability of clinically meaningful and consumer relevant hospital performance indicators as discussed above, but also relies on the fundamental agency relationship between a patient and their treating health professional. It also requires a level of health literacy which will vary with different patients and in different circumstances. In practical terms, useful consumer-orientated information will not be the same for all patients. While more and better information is preferable to less, the Commission should be cautious with the anticipated utility of this proposal for all patients and in different circumstances.

Measures to increase access to useful and relevant information with sufficient support will likely improve informed consumer decision-making. This would require information on the quality of care, patient outcomes, accessibility and waiting times to be publicly available. The use of proxy indicators and data that are not fit for purpose will not adequately meet this objective. The development and public reporting of indicators, should also be consistent across services (e.g. hospitals, general practice, pharmacy, allied health, community health services etc), and across the private and public sectors, to enable comparisons to be made of the quality and timeliness of outcomes achieved, innovations in scopes of practice and role substitution. Providing this information publicly may also provide additional incentive for public and private hospitals to undertake benchmarking and continuous quality improvement to enhance service delivery and patient outcomes.

More Contestable Approaches to Commissioning Services

While mechanisms to improve the operational performance of public hospitals are important, for the reasons discussed above, changes in the delivery of some public hospital services may not lead to an optimal overall system outcome. Responsibility for testing contestable approaches to the commissioning of public hospital services should be at jurisdictional level given that states and territories have responsibility for these services. State and territory governments in consultation with their local health networks will also be better placed to determine the local capacity to respond to a move towards contestability for defined services and to structure such an approach so as to minimise any negative externalities and to account for local workforce constraints.

The Study Report (page 101) raises the prospect of introducing a mechanism to "replace the management team (or board of the local health network) rather than switch to a non-government provider" as a mechanism to implement contestability within public hospitals.[10] These mechanisms are already in place across many of Australia's hospital networks, and have been exercised from time to time. However, it should be noted that this could not be unilaterally imposed by the Commonwealth as it would usurp state and territory authority over public hospitals and local health networks.

It is also emphasised that, as noted by the Commission and in submissions to this review process, the introduction of competition and contestability could lead to greater costs associated with tendering and contract management for providers and governments. There could also be a deleterious shift

[10] See page 101.

towards more short-term thinking. The appropriate management of clinical governance and oversight of the quality of services would also need to be well understood.

Complementary Reforms

It is vital that any reforms proposed by the Productivity Commission inquiry are considered as part of a coordinated approach to the delivery of healthcare services across the primary, acute, aged and disability care sectors. This should be with the aim of improved health outcomes and value, in addition to achieving innovation through improved models of care and greater integration of care both within and across sectors.

Reforms aimed at increasing the role of the private sector in delivering public health services will interact with, and have consequences for, other reforms currently under consideration in the health sector, for example in relation to private health insurance and in pricing for safety and quality in public hospitals. Both private and public hospitals are currently funded via a mix of government funding, private health insurance payments and individual (out-of-pocket) payments. Any changes to these funding mechanisms (including the ability of public hospitals to provide services for privately insured patients) would impact the operational environment in which the reforms contemplated by the Productivity Commission in this paper would be implemented.

Similarly, the review commissioned by the Australian Health Ministers Advisory Council into the National Health Performance Framework, evaluating the health system performance information and reporting framework will also have implications for any recommendations delivered by the Productivity Commission.

3 Proposal to Introduce Competition into End-of-Life Care

AHHA agrees with the findings of the Productivity Commission that effort and investment are required for improved access and user choice for end-of-life care, in addition to enhanced data development and reporting of end-of-life care data.

Any proposals related to end-of-life care will impact on highly vulnerable patients and their families. Therefore a high degree of caution must be exercised when considering changes to the market settings for end-of-life care. In particular, the AHHA urges the Commission to consider:

- The principle of user choice must be balanced with the knowledge that health literacy in Australia is low[11], services are fragmented and not well understood by many health professionals, let alone consumers, and that people who need end-of-life care are most often physically and/or mentally compromised. There is a need for appropriate mechanisms to support consumer choice for end-of-life care, recognising that this may change over time or with disease progression.

- End-of-life care is much less accessible outside of urban settings and there is limited workforce to support the need, regardless of whether the setting is public or private

- Assurance must be provided that neither secular nor non-secular end-of-life care is discriminated against, explicitly or tacitly

- The Guidelines for a Palliative Approach in Residential Aged Care and the Guidelines for a Palliative Approach for Aged Care in the Community Setting are currently under review by the Commonwealth Department of Health and any recommendations may be pertinent to the work of the Productivity Commission

- The strategic framework for provision of end-of-life care varies in each state and territory, and changes to this already fragmented system need to be carefully considered for knock on effects and pass the no disadvantage test prior to implementation

Current End-of-Life Services

Estimates from Australian research suggest that as many as 50–90 per cent of all people who die could benefit from access to palliative care services.[12] Evidence also indicates that reducing or delaying institutional care through home-based palliative care reduces healthcare costs incurred at the end of

[11] 59 per cent of Australians have health literacy skills that are below the minimum level required to allow them to meet the complex demands of everyday life (ABS. 2009. Australian Social Trends. Cat No 4102.0. Canberra).

[12] Rosenwax LK, McNamara BA, Murray K, McCabe RJ, Aoun SM and Currow DC. 2011. Hospital and emergency department use in the last year of life: a baseline for future modifications to end-of-life care. *The Medical Journal of Australia*, 194(11), 570–573.

life,[13,14,15,16,17,18] increases the likelihood of dying at home[19,20] and reduces the burden of symptoms.[21] Advance care planning in nursing home residents has demonstrated benefits including reduced numbers of hospitalisations, reduced numbers of residents dying in hospitals, and improved compliance with providing medical treatments consistent with people's preferences.[22]

Palliative care services have not been broadly embedded into the health system and are fragmented, with varying access and capacity across the country, depending on diagnosis, age, cultural background, geographical location, available resources and clinician knowledge. Local Primary Health Networks are well positioned to play a key role in the evaluation of community need, improved coordination, commissioning of services, and data collection and monitoring.

Legislative Framework

Legislation supporting advance care planning varies across jurisdictions, with *statutory directives* that require documentation that meets specific government requirements and, in some jurisdictions, *common law directives* that require a person's wishes, however they are documented, to be legally respected. AHHA recommends national harmonisation of legislation regarding advance care planning documents and substitute decision-makers. This should include agreed and consistent terminology, the use of national guidelines and standardised documentation, and consistent legislation to recognise advance care planning documents and ensure that they are authoritative and enforceable[23].

Information Technology

The My Health Record accepts uploads of advance care planning documents. However, access to these documents should be enhanced, with greater linkage and alerts to the existence of these documents in primary health, hospital and community IT systems. This will facilitate continuity and coordination

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[13] Georghiou T and Bardsley M. 2014. *Exploring the cost of care at the end of life*, *Report,* Nuffield Trust, London.

[14] Hongoro C and Finat N. 2011. A cost analysis of a hospital-based palliative care outreach program: Implications for expanding public sector palliative care in South Africa. *Journal of Pain and Symptom Management*, 41(6), 1015–1024.

[15] Langton JM, Srasubkul P, Reeve R, Parkinson B, Gu Y, Buckley NA, Haas M, Viney R and Pearson SA. 2015. Resource use, costs and quality of end-of-life care: observations in a cohort of elderly Australian cancer decendents. *Implementation Science*, 10(1), 1–14.

[16] McCaffrey N, Agar M, Harlum J, Karnon J, Currow D and Eckermann S. 2013. Is home-base palliative care cost-effective? An economic evaluation of the Palliative Care Extended Packages at Home (PEACH) pilot. *BMJ Supportive & Palliative Care*, 3(4), 431–435.

[17] Smith S, Brick A, O'Hara S and Normand C. 2014. Evidence on the cost and cost-effectiveness of palliative care: a literature review. *Palliative Medicine*, 28(2), 130–150.

[18] Tanuseputro P, Wodchis WP, Fowler R, Walker P, Bai YQ, Bronskill SE and Manuel D. 2015. The health care cost of dying: a population-based retrospective cohort study of the last year of life in Ontario, Canada. *PloS one*, 10(3), e0121759.

[19] Gage H, Holdsworth LM, Flannery C, Williams P and Butler C. 2015. Impact of a hospice rapid response service on preferred place of death, and costs. *BMC Palliative Care*, 14(75), 1-11.

[20] Shepperd S*,* Gonçalves-Bradley DC*,* Straus SE *and* Wee B. 2016. Hospital at home: home-based end-of-life care. *Cochrane Database of Systematic Reviews, Feb 18(*2)*, article no. CD009231.*

[21] Gomes B, Calanzani N, Curiale V, McCrone P and Higginson IJ. 2013. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane Database of Systematic Reviews*, June 6(6), article no. CD007760.

[22] Martin RS, Hayes B, Gregorevic K and Lim WK. 2016. The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review. *Journal of the American Medical Directors Association*, 17(4), 284–293.

[23] Jones A and Silk K. 2016. Improving End-of-Life Care in Australia. *Deeble Institute for Health Policy Research*, Deeble Issues Brief No. 19.

of care, improve clinician awareness, and assist in providing care that aligns with advance care planning decisions. Additionally, such systems could potentially prompt discussion and documentation of advance care planning at key times in the patient journey.

Supporting Health Professionals

Recognising and diagnosing dying is marred by prognostic uncertainty. This complex clinical decision commonly relies on the skill and experience of the clinician, which can be complemented by clinical tools developed to assist in recognising the dying patient and avoiding potentially harmful and futile treatments.[24,25,26] Raising clinician awareness and access to screening tools may help to minimise prognostic uncertainty and futile care, promoting transparent conversations about treatment choice and care limitations.

For advance care planning to be effective, planning and discussion around people's health care preferences need to become an ongoing part of routine clinical practice. To achieve this, clinician training must include caring for people at end of life and should include medical practitioner responsibility for recognising dying and supporting end of life. Including end-of-life care in continuous professional development, through providing access to peer support mentoring and clinical supervision of all health care providers, will support medical practitioners and clinicians in managing the emotional and ethical challenges of these discussions.

Public and User Awareness

Failure to talk about and plan for death is one of the most significant obstacles to improving the quality of dying. Population health awareness campaigns covering dying, death and end-of-life care will assist in lessening misconceptions and improving understanding of the limitations of healthcare, and the potential adverse consequences of futile health care, especially at the end of life. Such campaigns could also support people in making their choices known, and engaging in advance care planning.

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[24] Cardona-Morrell M and Hillman K. 2015. Development of a tool for defining and identifying the dying patient in hospital: Criteria for Screening and Triaging to Appropriate aLternative care (CriSTAL). *BMJ Supportive & Palliative Care*, 5(1), 78–90.

[25] Kennedy C, Brooks-Young P, Gray CB, Larkin P, Connolly M, Wilde-Larsson B, Larsson M, Smith T and Chater S. 2014. Diagnosing dying: An integrative literature review. *BMJ Supportive and Palliative Care*, 4(3), 236–270.

[26] Richardson P, Greenslade J, Shanmugathasan S, Doucet K, Widdicombe N, Chu K and Brown A. 2014. PREDICT: a diagnostic accuracy study of a tool for predicting mortality within one year: who should have an advance healthcare directive? *Palliative Medicine*, 29(1), 31–37.

4 Proposal to Introduce Competition into Public Dental Services

As noted in the Study Report, the majority of dental health care in Australia is privately funded and performed in private practice. While there may be scope to introduce greater competition, contestability and user choice in public dental services, this is unlikely to have a significant impact on the ability of Australians to access timely and affordable dental healthcare without appropriate funding and adequate availability of dental healthcare providers at the local level. This respectively reflects an absence of universal access to dental healthcare and limitations with respect to workforce and physical capacity.

Much of the unmet need for dental health care in Australia is due to a lack of funding (ie dental care is not part of Australian universal healthcare). This implies that introducing competition and contestability to public dental services would in isolation have perhaps only limited impact on meeting need, contributing to preventive health and avoiding costly potentially preventable hospitalisations. Furthermore, if public dental services were opened to private competition, there would be a need to ensure that the same quality and safety standards applied to all providers. In this context, the availability of private dental services may also be problematic - as an area becomes more remote there are less likely to be private providers servicing these markets.

The following comments are provided in relation to the proposals on the cost for competition and contestability with public dental services.

Scope to Improve Outcomes

The current fee-for-service funding model in Australian dentistry places the focus on throughput of patients rather than sustained oral health outcomes being achieved. The most effective way to address this concern is to have an agreed set of oral health outcome indicators and the necessary data collection processes to support assessment against this framework. As a first step in this regard, Dental Health Services Victoria is currently developing a set of oral health outcome indicators with the International Consortium for Health Outcomes Measurement (ICHOM).

The Study Report (page 116) also states that, “government-operated clinics can limit the responsiveness of services to user preferences”. However, referring to South Australia as an example, dental funding is initially distributed based on the number of eligible people in a given area, and if public dental facilities are not available or reasonably accessible within that area, vouchers are then issued to eligible patients to access treatment from private providers. Furthermore, a range of programs targeted at sub-groups with identified high needs have been developed including for those living in aged care facilities, older people living in the community, Aboriginal and homeless people. There is also a fly-in-fly-out dental program for rural and remote areas where with neither public nor private providers.

The Study Report states that there is only minimal public performance reporting. While improvements to performance reporting can always be made, particularly with respect to a standardised outcomes framework, most jurisdictions collect data on patient dental treatment and dental health status with this data then used for internal decision-making and shared with the Australian Research Centre for Population Oral Health at the University of Adelaide and the Australian Institute of Health and Welfare for analysis and publication.

Equity

The Study Report statements on equity must be recognised in the context of how funding is provided for public dental health care, the socioeconomic distribution of need and access to oral healthcare,

and the broader social determinants of health in which dental healthcare needs arise. By policy construct, adults can typically only access public dental care if they are a concession card holder.

Efficiency and Accountability

While there are limited national efficiency and accountability measures published, the National Oral Health Plan has a set of key performance indicators recommended for reporting to health ministers. This should ideally be complemented by a broader suite of oral health outcome indicators. Comparisons of public and private access to dental services using currently available service data is also limited due to the absence of "per patient" level of data.

An example of the use of performance reporting is available from South Australia where the cost effectiveness of their public dental services is routinely compared to the cost of delivering these services through the private sector. These reviews consistently find that (for adults) it costs around 30 per cent more to provide a course of general dental care in the private sector than in the public sector. The primary reason for this cost difference is that private dentists consistently provide more treatment to the patient than would be provided by a public dentist. This is a clear example of how the availability of a private sector supply alternative does not necessarily lead to reduced costs or a more efficient allocation of limited health resources.

While this may be indicative of over-servicing by private providers, it is also possible the budget constraint within which public dental services operate imposes an intrinsic prioritisation of which services are provided to whom in order to gain the greatest marginal benefit. To the extent this explanation is true, this would represent a clear example of the guiding principle identified at the start of this submission where individually short term rational decisions (in this case, by private providers) should not be at the expense of long term sustainable health outcomes or broader whole of system efficiency (technical and allocative).

Such market behaviour of private dentists operating under a publicly funded dental program was evident in the now closed Medicare Chronic Disease Dental Program. In South Australia, many private providers "cherry picked" complex and lucrative treatment items of care up to the Scheme's $4,250 cap and then referred the patient back to the public dental sector for the more basic general dental care.

Responsiveness

The geographic accessibility of the private sector for dental services may not be matched by its socio-demographic accessibility. While income constraints is an obvious issue for many in need of dental care, factors related to the social determinants of health can also play a part. It should also be noted that in some rural areas, local private providers are unable to satisfy private demand and are unwilling to treat subsidised public patients.

Many public dental services provide significant preventive and health promotion programs aimed at preventing oral health disease rather than fixing it. Once people have a disease, some can be managed with preventive measures while others require restorative care.

Factors Influencing the Potential Benefits of Reform

User Characteristics

The Study Report identifies that there is a disproportionate share of adult public dental health users from disadvantaged areas. Given that the eligibility for public dental health services is largely constrained to concession card holders, this is hardly surprising. Instead, consideration of the social

determinants of health may provide a more powerful insight into understanding who is more likely to need access to public dental healthcare.

The Study Report acknowledges that disadvantaged populations include hard to reach vulnerable communities. The challenge is to identify the most appropriate response to not only treating oral disease in these communities, but as importantly, providing effective preventive oral healthcare. The public sector has a major role in facilitating prevention through a range of health promotion programs, a role not within the scope of private providers who are instead focused on the provision of treatments. While evaluation of these programs is not comprehensive, there is evidence of positive impacts on oral health outcomes associated with these preventive health measures.[27]

Supply Characteristics

Models of care that propose alternative mixes of workforce components, such as being developed currently by Dental Health Services Victoria, may assist in achieving a more cost efficient workforce. Other innovations in service delivery models include teledentistry which is being used in the public dental sector in NSW, Victoria and Queensland. Teledentistry has the potential to improve access and reduce inequality in the provision of oral healthcare services.

The Study Report also notes that emergency care comprises a greater share of services provided to public dental patients and there is proportionately less preventive and restorative care provided by public clinics. This profile of services largely results from public dental services needing to respond to demand for emergency treatments. Meeting this urgent demand then leaves diminished resources to address the needs of non-emergency patients. This reflects the varying objectives of the public and private dental care systems.

In non-emergency public dental care, a balanced and targeted mix of preventive and restorative care is provided tailored to the individual's disease risk. The private sector is more likely to provide a basket of preventive services irrespective of the patient's disease risk, potentially leading to over-servicing.

The Potential Costs of Reform

With the many program changes over the years and jurisdictional differences in public dental services offered, consumers are at risk of being confused or uninformed with any changes to public dental services and provider options. Anecdotal evidence suggests that many consumers are not aware of current services which they or their dependents may be eligible to receive. The guiding principles stated at the start of this submission are worth repeating with respect to the crucial importance of health literacy and truly informed consent.

There is a need for all service delivery organisations to be accredited against the National Safety and Quality Health Service Standards. While accreditation is not a guarantee of safety and quality in dental care, it is important that some form of quality measure is applied. The collection of standardised and meaningful data should also be made compulsory, and in particular, with health outcome indicators including clinical indicators.

Caution should also be applied to extrapolation of the experience with the Child Dental Benefit Scheme which has only been reviewed on its administrative processes. A more comprehensive assessment of

[27] Petersen P and Kwan S. 2009. World Health Organization global oral health strategies for oral health promotion and disease prevention in the twenty-first century. Prävention und Gesundheitsförderung, 4(2), 100–104.

the public health benefits from public dental health schemes must take into account the outcomes achieved, including the value of preventative oral health interventions.

Finally, there is a barrier to more effective workforce reform as a result of dental therapists, dental hygienists and oral health therapists not being able to be issued their own provider number and having to instead rely on dentists' provider numbers for the services they perform. While dentists have opposed provider numbers for these other clinicians, enabling the allocation of provider numbers to these clinicians would contribute to a greater use of the skills of the full dental workforce and enhance overall system capacity and flexibility.

5 Proposal to Introduce Commissioning into Family and Community Services

The AHHA welcomes findings from the Productivity Commission with respect to the inconsistent and limited strategic engagement of government with service providers, the absence of effective systems to identify local community needs, the negative impact of short term contracts and uncertainty related to ongoing funding, the stifling of innovation and onerous reporting requirements.[28] The points in Finding 8.1 should be further developed to address these serious concerns that hamper community service provision, rather than general recognition for the need for improvements to government commissioning. This should instead acknowledge and embrace the positioning of local community and not-for-profit organisations to recognise and respond to local community needs.

As local markets adapt to new measures of competition or contestability, it is also important to recognise the value of existing social capital and local relationships between providers and clients and to preserve these where possible.[29] We note that the Productivity Commission has separately recognised the benefits of social capital to local communities.[30]

It is also emphasised that, as noted by the Commission and in submissions to this review process, the introduction of competition and contestability in family and community services could lead to greater costs for providers and governments associated with tendering and contract management. There could also be a deleterious shift towards more short term thinking.

[28] See pages 31 and 32.
[29] Kerr-Smith E. 2015. Annie's Story, and Getting the NDIS Right. The Mandarin (accessed 10 October 2016).
[30] See page 38.

6 Proposal to Introduce Competition into Human Services in Remote Indigenous Communities

While some competitive and contestable service arrangements are already in place in remote Indigenous communities, both private and public funded service arrangements are often characterised by less capacity to deliver the full range of health services to meet community needs, and particularly, to provide these services on a regular basis.

The role of Aboriginal Community Controlled Health Organisations (ACCHOs) is vital in providing culturally appropriate care and in circumstances where private service provision will often not be feasible. ACCHOs must continue to be supported to fulfil this role and to develop Indigenous capacity within the healthcare sector.

There is also a role for NGOs to work in partnership with ACCHOs to complement available services, but these arrangements should be considered as supporting and complementary, not as a substitution for Indigenous-controlled, culturally appropriate services.

The AHHA agrees with the Study Report Finding 7.1 as it relates to Aboriginal and Torres Strait Islander people living in remote communities that identifies the importance of culturally appropriate care, the need to better coordinate service delivery and reduce fragmentation, greater community voice in service design and the importance of stable policy settings.

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